Inspection Report

We are the regulator: *Our job is to check whether hospitals, care homes and care services are meeting essential standards.*

The Croft (RCH) Limited

Hooke Hill, Freshwater, PO40 9BG

Tel: 01983752422

Date of Inspection: 16 October 2012

Date of Publication: December 2012

We inspected the following standards in response to concerns that standards weren't being met. This is what we found:

Care and welfare of people who use services	✖	Enforcement action taken
Meeting nutritional needs	✖	Enforcement action taken
Safeguarding people who use services from abuse	✓	Met this standard
Management of medicines	✖	Enforcement action taken
Safety and suitability of premises	✖	Action needed
Requirements relating to workers	✖	Enforcement action taken
Staffing	✖	Action needed
Assessing and monitoring the quality of service provision	✖	Action needed

Details about this location

Registered Provider	The Croft (RCH) Limited
Registered Manager	Miss Sharon Anne Alsop
Overview of the service	The Croft RCH Ltd is registered to accommodate a maximum of 21 people. The home is situated on the Isle of Wight. There is no nursing provided at the home and they have a registered manager.
Type of service	Care home service without nursing
Regulated activity	Accommodation for persons who require nursing or personal care

Contents

When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

Summary of this inspection

Why we carried out this inspection

We carried out this inspection in response to concerns that one or more of the essential standards of quality and safety were not being met.

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, reviewed information sent to us by other organisations, carried out a visit on 16 October 2012 and observed how people were being cared for. We checked how people were cared for at each stage of their treatment and care, talked with people who use the service and talked with staff.

We also spoke to a Healthcare Professional.

What people told us and what we found

We spoke with six people who were living at the home. Some people were unable to tell us about their experiences due to their cognitive problems. We observed how people spent their time, the support they received from staff. We also spoke to a visiting healthcare professional and the staff.

People told us that they were treated with well and "it was all right" when asked about what it was like living at the home. We observed that the staff behaved in a respectful manner when speaking to people. A visiting healthcare professional told us that they visited one of the people regularly and found that they had settled at the home. We found that although initial assessments were completed, people care plans did not reflect their current needs and how these would be met. Where risks were identified such as falls, there were limited action plans to show how these would be effectively managed.

Healthcare professionals advice were sought and detailed guidance was provided to staff . These were not always followed by the staff which meant that people did not receive the care they needed. People were not always supported to be able to eat and drink sufficient amounts to meet their needs.

We found that the arrangements for the management of people's medicines were not adequate and action was needed. There was not always adequate staff and staffing hours were eroded by non care duties. There was a lack effective system to monitor the quality and service delivery.

You can see our judgements on the front page of this report.

What we have told the provider to do

We have asked the provider to send us a report by 22 December 2012, setting out the

action they will take to meet the standards. We will check to make sure that this action is taken.

We have referred our findings to Fire Safety Assessor. We will check to make sure that action is taken to meet the essential standards.

We have taken enforcement action against The Croft (RCH) Limited to protect the health, safety and welfare of people using this service.

Where providers are not meeting essential standards, we have a range of enforcement powers we can use to protect the health, safety and welfare of people who use this service (and others, where appropriate). When we propose to take enforcement action, our decision is open to challenge by the provider through a variety of internal and external appeal processes. We will publish a further report on any action we take.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

Our judgements for each standard inspected

Care and welfare of people who use services ✖ Enforcement action taken

People should get safe and appropriate care that meets their needs and supports their rights

Our judgement

The provider was not meeting this standard.

People did not experience care, treatment and support that met their needs and protected their rights. The planning and delivery of care and treatment did not meet the people individual needs. People at risk of weight loss were not always appropriately supported.

We have judged that this has a moderate impact on people who use the service and have taken enforcement action against this provider. Please see the 'Enforcement action' section within this report.

Reasons for our judgement

Peoples' needs were assessed and some care plans had been developed to meet the assessed needs of people. We looked at the care plans and associated records for six people who use the service. The care records for one person showed that risks had been assessed, and reflected their needs and preferences. This included support with personal care. The risk assessment covered their mobility, risk of falls, bathing, eating and choking. The plan included details of strategies for dealing with their disruptive behaviour and this showed that advice was sought from external healthcare professional.

We found that care plans and risk assessments for three people were not always consistent and did not reflect people's individual risks such as moving and handling and mobility. We saw staff assisting one person to transfer at lunchtime and they did not use appropriate moving and handling techniques. This person was lifted under the arms and their feet dragged on the floor.This was due to this person's inability to fully support their weight. Their moving and handling assessment was blank and in the afternoon we observed two staff using a handling belt to transfer this person. People were at risk of inconsistent care as their plans of care did not contain information to guide staff's practices in providing continuity of care. For two other people staff did not follow their care plans that contained detailed instructions about people's needs such as dietary supports to ensure that they were not put at risk . This meant that people's care was not planned and delivered in line with their individual needs.

The staff in charge on the day of the visit told us that there were eight people who were at high risk of leaving the home unsupervised and putting themselves at risk. We found that there were no assessments and plans of care in place to manage this. We observed that the risk assessments and action plans for two people were being developed on the day of our visit. A staff member told us that they were not aware of a risk support plan for a

person when we asked them about it. We also discussed this with the manager who told us that this person was not at risk of leaving the building.

A person's records contained detailed information about their challenging behaviour. The care record included"do not resuscitate" information. We found that it was not clear how this decision was reached. There was no formal do not resuscitate form that had been completed. There was no record of an assessment of capacity or any 'best interest' decisions and no evidence that their next of kin had been involved.

The care records for another person showed that they were independently mobile and their history of falls assessment record was blank. A staff member told us that this person was "very unsteady". Their daily records showed that they had suffered a number of falls and injuries.

Another person had been admitted in August 2012, there was a detailed life history provided by their family. This person's record showed that they had lost weight and had been refusing to eat. There was no nutritional assessment undertaken and no care plan to show how the staff would be meeting the needs of this person. The registered manager told us that they expected to see that care plans should have been developed for this person and could not understand why this had not been put in place. We found their personal risk assessment was blank. An assessment of their physical health, social and leisure were all incomplete. This meant that care plans were inadequate; peoples' needs were assessed and care and treatment was not planned and delivered in line with their individual needs.

A person's record showed that between May 2012 and September 2012 they had lost a considerable amount of weight The staff could not tell us why this person had not been weighed in October 2012. Their care plans did not show what action the staff were taking to monitor this person's weight and nutritional status. The deputy manager could not tell us why this person had lost this amount of weight. There was no evidence to show that you had taken action regarding the recorded weight loss. This meant that proper steps were not in place to ensure that people were protected against the risks of receiving inappropriate care and treatment because steps had not been taken to meet their individual needs and protect them from further weight loss.

We found that following an assessment by Speech and Language Team (SALT), a person was to receive fluids thickened to stage 2 and be provided with food that was moist and "fork mashable", requiring little chewing and be served with a sauce due to a risk of choking. Their records showed that staff were failing to follow the guidance from SALT and they were provided with food that may in light of advice from SALT which put them at high risk of choking. The staff could not tell us why they had been provided with these types of food. This was against the recommendations of the SALT team and meant that there was a failure to meet the assessed care needs of this person. We saw record of an incident where this person had choked having eaten normal food which was not mashed and provided to them in accordance with their assessed needs.

Meeting nutritional needs ✖ Enforcement action taken

Food and drink should meet people's individual dietary needs

Our judgement

The provider was not meeting this standard.

People were not protected from the risks of inadequate nutrition and dehydration. People were not always supported to be able to eat and drink sufficient amounts to meet their needs. People were put at risk by being provided with food that may not be suitable to meet their assessed needs.

We have judged that this has a major impact on people who use the service and have taken enforcement action against this provider. Please see the 'Enforcement action' section within this report.

Reasons for our judgement

There was a failure to monitor people's food and fluid intake when they are at risk of poor nutrition or dehydration and action was not taken as necessary. We found during our visit, that you were failing to make appropriate arrangements to ensure that people receive adequate nutrition and hydration as prescribed and as a consequence you were putting their health, safety and welfare at risk.

A person had been assessed as high risk of choking and the speech and language therapist (SALT) had advised that they should be provided with "fork mashable" food. We observed they had been served a meal that was chopped up in pieces. A staff member told us that this person should not be provided with this type of food due to their risk of choking. The staff agreed that they should also be provided with a teaspoon, as advised by SALT team due to their risk of retaining a large bolus of food in their mouth. We observed that this person was not given suitable food nor a teaspoon or any other form of staff support in order to assist them to eat their lunch. Their record also showed that they had suffered an episode of choking.

Another person's care record showed that they had been assessed as "below average BMI and very high risk" to their nutritional status. Their records did not contain adequate details of the food and fluids that they had received. The staff told us that this person was at risk and were having their food and fluid monitored. The staff told us that food and fluid records were completed at the end of the shifts. They agreed that the records may not be accurate as staff may not recall exactly what food, fluids and the quantities people had received. This meant that people were not sufficiently protected from the risk of receiving inadequate food and fluids because they were not being appropriately monitored and supported to eat and drink.

The records also showed that a person had lost a considerable amount of weight. There was a blank malnutrition universal screening tool (MUST) form in their file, but no

indication that it was being used or was understood by the staff. The staff in charge told us that the MUST tool was not being used and staff had not received training. This meant that people's nutritional status was not appropriately monitored any changes and nutritional risks could not be identified.

We observed that another person had not eaten any of their lunch and had been refusing food according to the staff. This person had also lost weight since admission. Their food and fluids records seen showed that they had received little food and fluids. The staff could not tell us what other support this person was receiving and had not made a referral to seek support for this person.This meant that this person had not been supported to receive an adequate amount of food and fluid to meet their needs.

The six people's records we looked at showed they had lost weight and there was no action plan in place to demonstrate how this was being managed. This meant that people's nutritional risks had not been considered and appropriate support put in place to protect them from further weight loss. Appropriate actions were not taken to ensure that people were protected from the risk of dehydration and malnutrition.

Safeguarding people who use services from abuse ✓ Met this standard

People should be protected from abuse and staff should respect their human rights

Our judgement

The provider was meeting this standard.

People who use the service were protected from the risk of abuse, because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening.

Reasons for our judgement

The provider responded appropriately to any allegation of abuse. The home had in place a safeguarding policy and procedure which included the local authority safeguarding procedures. The manager described the procedure that they would follow and alert the safeguarding team as needed.

We spoke with four staff who were able to describe the types of abuse that could occur and the action they would take if abuse was suspected. They were confident that they could approach the manager and actions would be taken to protect people. The staff also told us that they had completed training in safeguarding adults. Two staff said that they had also undertaken training in physical intervention.

Management of medicines ✖ Enforcement action taken

People should be given the medicines they need when they need them, and in a safe way

Our judgement

The provider was not meeting this standard.

People were not protected against the risks associated with medicines because the provider had no appropriate arrangements in place to manage medicines. People did not always receive their medicines when they needed them. Medicines received into the home were not handled and disposed of in a safe way.

We have judged that this has a major impact on people who use the service and have taken enforcement action against this provider. Please see the 'Enforcement action' section within this report.

Reasons for our judgement

We visited the home to carry out a responsive review of compliance. We found that arrangements for the handling that included obtaining, safe storage, prescribing, dispensing, preparation, administration, monitoring and disposal of medicines in the home were not adequate. We found that controlled medicines received into the home were not handled and managed safely to protect people who use the service.

Although the medication administration record (MAR) records showed that people had received their medicines, this may not be an accurate reflection of practices. We found during our visit, that appropriate arrangements to ensure that people received their medicines as prescribed were inadequate.

A person who was a diabetic was prescribed two medications to manage their diabetes. The medication administration record (MAR) charts showed that they had received their morning medicines on 16 October 2012. Their MAR records had been signed to confirm this. We found that all their morning medicines were still in the trolley when we checked in the afternoon. The staff in charge told us they did not know why they had not received their medicines. This meant that appropriate arrangements were not in place for the safe administration of medicines. This person was not protected from the risks associated of not receiving their medicines as prescribed.

Another record showed that a person had been prescribed two controlled medications for pain which were administered intravenously via a syringe driver. The controlled drug register showed that there should be five ampoules of Diamorphine 5mg and two ampoules of Diamorphine 30 mg left in stock. This was recorded in the controlled drug register at the home. There were none available when we checked. The staff in charge told us that they thought these would have been returned to the pharmacy. There was no record to show that these seven ampoules of Diamorphine had been sent to the pharmacy. The staff was unable to confirm that these seven ampoules of Diamorphine had

been sent and received in the pharmacy. There are legal requirements for the storage, administration, records and disposal of controlled drugs (CDs). These are set out in the Misuse of Drugs Act Regulations 2001 (as amended). The guidance document from the royal pharmaceutical society, 'handling medicines in social care setting' recommend that these requirements are followed in a care setting. There was a failure to protect people from the risk associated with unsafe management of controlled medicines.

We were told by the manager that a person was receiving one medicine covertly. This was a tablet that was given to them in their coffee. The staff in charge told us that they were receiving all their medicines covertly. There was no arrangement in place for giving medicines covertly where needed and in accordance with the Mental Capacity Act 2005. The staff in charge could not tell us if this had been agreed by their GP and any advice sought from the pharmacist. This would ensure that they received their medicines correctly and any adverse effect of crushing and breaking capsules had been clearly risk assessed. This meant that appropriate arrangements were not in place for the safe administration of medicines. This practice did not protect people from the risks associated with the unsafe management of medicines.

We found that there were large discrepancies in the stock of people's medicines. The staff in charge told us that they carried out an audit of medicines. If the audits had been carried out effectively, they would have identified the failings we found during the inspection and appropriate action could have been taken to address them. The findings of the inspection led us to conclude that there were not appropriate arrangements in place to protect people from the risks associated with the unsafe use and management of medicines. We found that out of the 10 medicines records we checked, nine of these contained discrepancies such as missing tablets that the staff could not account for. This meant that people were not receiving their medicines as prescribed and impacted on their health and welfare.

We asked to see the information relating to 'when required' medication to ensure that it was only administered when it was safe to do so. There was very little written information recorded to inform care staff on when it would be appropriate to administer these medicines. Staff told us that most of the people would not be able to tell them when they needed these medicines due to their cognitive problems. This meant people may not receive their medicines as and when they needed them. People were not protected from the risks associated with the unsafe use and management of medicines.

Safety and suitability of premises ✖ Action needed

People should be cared for in safe and accessible surroundings that support their health and welfare

Our judgement

The provider was not meeting this standard.

People who use the service, staff and visitors were not adequately protected against the risks of unsafe or unsuitable premises. The emergency access to the fire doors was not risk assessed and arrangements for evacuation were inadequate.

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

The provider had taken steps to provide care in an environment that was suitably designed and adequately maintained. We looked at eight bedrooms and the various communal areas at the home. We found that the home was clean except for one bedroom that had an offensive odour and with brown patches on the carpet. We brought this to the attention of the staff member in charge who told us that this would be addressed.

We found that the home was accessible to people including those with limited mobility. There were security arrangements in place to protect people who use services and people were able to access the enclosed gardens. There were low level gates to the side of the home that were locked and we noted that one of the locks looked new. We found the front door was secure and required a staff member to allow us access to the premises.

During our visit we found that the staff had turned off the alarm to the back fire door as they were stood outside the area smoking. The staff in charge told us that the fire doors were not alarmed until 21:00. One of the doors had a keypad lock, and the manager confirmed that this fire door was not linked to the fire alarm system, despite it being clearly marked as a 'Fire Exit'. This would have allowed the door to be de-activated in the event of a fire and people to get out. There were no risk assessments in place and it was unclear what arrangements were in place to ensure people were able to get out safely in the event of a fire. We have referred this to the fire safety officer on the Isle of Wight to look into.

The health and safety team from the community were assessing the environment at the time of our inspection and made some recommendations. These included fitting of window restrictors and for the fire doors alarms to be active at all times.

Requirements relating to workers ✖ Enforcement action taken

People should be cared for by staff who are properly qualified and able to do their job

Our judgement

The provider was not meeting this standard.

There were ineffective recruitment procedures that failed to ensure that the health and welfare needs of people were met by staff who were fit, appropriately qualified to do their job.

We have judged that this has a moderate impact on people who use the service and have taken enforcement action against this provider. Please see the 'Enforcement action' section within this report.

Reasons for our judgement

We looked at seven staff records for the arrangements that the registered person had in place to ensure that no person was employed for the purposes of carrying on a regulated activity unless that person was fit to do so.

We found that staff a staff member had started work in July 2012. Their file did not contain any records of criminal record bureau (CRB) or independent safeguarding authority checks (ISA) had been completed for this person and this information was not available. Another staff record showed that care they had completed an application form. There were no references, and no record that CRB and ISA first checks had been completed. This staff member had been working at the home. This information of relevant checks was not available when we asked for it.

The records showed that another staff member ad started working at the home on 18 June 2012. On the day of the visit this person was working in the kitchen until 17:00 and then providing care until 20:00. Their file could not be located when we asked to see it.

One staff member we were told had left their employment at this location in January 2012. They had returned to work again at the home in June 2012 and the only records available were those that had been archived in January 2012. The duty roster seen showed that these people had been working at the home. This meant that the registered persons were failing to ensure that all necessary checks were completed prior to the staff starting work. This practice may put vulnerable at risk of poor practice and abuse, as the registered persons did not operate a robust recruitment process.

Staffing ✖ Action needed

There should be enough members of staff to keep people safe and meet their health and welfare needs

Our judgement

The provider was not meeting this standard.

People were cared by staff who knew them well; their health and welfare needs were not met always by sufficient numbers of appropriate staff. The provider could not demonstrate that there were sufficient numbers of staff with the right competencies, skills and experience to meet the needs of people who use services at all times.

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

We looked at the duty roster that showed that there was an average of four staff during the day and night duty had two staff members. We spoke with five staff who told us that they thought there were adequate staff to meet people's needs. We observed that the availability of staff to support people was variable. We observed people putting themselves on the floor and there were no staff around to support them. This posed a risk to the person and other people who were walking around. Staff told us that a number of people would require two staff members to support them due to their challenging behaviours.

We found that during the visit, there were two staff taking a break outside the building that left one staff member to support 20 people. The duty roster did not accurately reflect staff availability. For example the roster showed that the manager was marked as "office" which meant she would be on duty on the day of our visit, but had taken the time off and was not working.

There were no domestic and laundry staff at the weekend, the staff told us that they undertook these tasks. A staff member told us that the number of people and their care needs did not alter at weekends such as people did not go on home's leave. The kitchen staff finished 14:00 and a care staff told us that they would work in the kitchen until 17:00 and then would be providing care. This meant that care hours were eroded by domestic duties and may impact on people as staff may not be available to support people as needed.

There was no system to demonstrate that the staff had carried out a need's analysis and risk assessment, as the basis for deciding sufficient staffing levels. The home was accommodating a high number of people with complex needs that required a lot of support and constant supervision. Staff were able to tell us about training they had completed such as safeguarding adult and dignity and quality of life. A staff member said that they had recently completed their food hygiene training. The induction records for three staff showed that these were incomplete although these people had started working at the home since June and July 2012. The training records were not available for the staff's

records that we looked at. We asked to see the home's training plan, this could not be located at the time of our inspection.

Assessing and monitoring the quality of service provision ✖ Action needed

The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

Our judgement

The provider was not meeting this standard.

The provider did not have an effective system to regularly assess and monitor the quality of service that people receive. There was a lack of process to identify, assess and manage risks relating to the health, welfare and safety of service users and others who may be at risk from the carrying on of the regulated activity.

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

The person in charge told us that they had regular service users' meetings and any issues raised were addressed. We saw that the last report from the provider's assessment of the service was undertaken in April 2012 and no other information was available. Staff told us that they thought these checks were carried out regularly but this may not have occurred since April.

We saw that a fire risk assessment had been carried out by an external person in August 2012. The report had identified eight areas that needed immediate attention. These included care plan and risk assessment for the risk of arson attempts and personal emergency for all people accommodated. The provider was required to update the fire action plan to include procedures for night time evacuations. The provider had to make provision for fire equipments to be available in designated areas. We asked to see the action plan and the staff in charge said that they were going to start this; however this was received six weeks ago.

At the last visit in April 2012, the manager told us that they were introducing an outcome based audit tool and they carried out medicines audit, although they did not record the outcome. We identified a number of concerns during this visit that had not been picked up by their own quality or health and safety checks that should be carried out. Their audit of medicines failed to identify the serious concerns we found regarding medicines, management. There was no evidence that learning from incidents and investigations took place and appropriate changes were implemented.

The staff in charge told us that they had not received any complaints and could not locate the complaints' log when we asked to see it. Three of the staff we spoke with were confident that any concerns reported would be looked into and responded to appropriately. The provider took account of complaints and comments to improve the service.

This section is primarily information for the provider

Action we have told the provider to take

Compliance actions

The table below shows the essential standards of quality and safety that **were not being met**. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010** **Safety and suitability of premises**
	How the regulation was not being met: People who use the service, staff and visitors were not adequately protected against the risks of unsafe or unsuitable premises. Regulation 15(1)
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010** **Staffing**
	How the regulation was not being met: People were not always supported by sufficient staff with the right experience, qualifications and skills to support people. Regulation 22
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010** **Assessing and monitoring the quality of service provision**
	How the regulation was not being met: There was a lack of process to identify, assess and manage risks relating to the health, welfare and safety of service users

This section is primarily information for the provider

	and others who may be at risk from the carrying on of the regulated activity. Regulation 10(1)(a) (b),2 (c) (i), 2(e).

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

CQC should be informed when compliance actions are complete.

We will check to make sure that action has been taken to meet the standards and will report on our judgements.

This section is primarily information for the provider

✖ Enforcement action we have taken to protect the health, safety and welfare of people using this service

Enforcement actions we have taken

The table below shows enforcement action we have taken because the provider was not meeting the essential standards of quality and safety (or parts of the standards) as shown below.

We have served a warning notice to be met by 30 November 2012 This action has been taken in relation to:	
Regulated activity	Regulation or section of the Act
Accommodation for persons who require nursing or personal care	**Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010** **Care and welfare of people who use services**
	How the regulation was not being met: People did not experience care, treatment and support that met their needs and protected their rights. The planning and delivery of care and treatment did not meet the people individual needs. Regulation 9 (1) (a) (b).
We have served a warning notice to be met by 30 November 2012 This action has been taken in relation to:	
Regulated activity	Regulation or section of the Act
Accommodation for persons who require nursing or personal care	**Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010** **Meeting nutritional needs**
	How the regulation was not being met: People were not protected from the risks of inadequate nutrition and dehydration. People were not always supported to be able to eat and drink sufficient amounts to meet their needs. Regulation 14(1)(a) (b) (c).

This section is primarily information for the provider

We have served a warning notice to be met by 30 November 2012 This action has been taken in relation to:	
Regulated activity	Regulation or section of the Act
Accommodation for persons who require nursing or personal care	**Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010** **Management of medicines**
	How the regulation was not being met: The registered person did not have adequate arrangement in place to protect people against the risks associated with the unsafe use and management of medicines. Regulation 13.
We have served a warning notice to be met by 30 November 2012 This action has been taken in relation to:	
Regulated activity	Regulation or section of the Act
Accommodation for persons who require nursing or personal care	**Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010** **Requirements relating to workers**
	How the regulation was not being met: There was an ineffective recruitment procedures that failed to ensure that the health and welfare needs of people were met by staff who were fit, appropriately qualified to do their job.Regulation 21(a)

For more information about the enforcement action we can take, please see our *Enforcement policy* on our website.

About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of dentists and other services at least once every two years. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times but we always inspect at least one standard from each of the five key areas every year. We may check fewer key areas in the case of dentists and some other services.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✓ **Met this standard**	This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.
✖ **Action needed**	This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.
✖ **Enforcement action taken**	If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. We make a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation) from the breach. This could be a minor, moderate or major impact.

Minor impact – people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

Moderate impact – people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

Major impact – people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

Respecting and involving people who use services - Outcome 1 (Regulation 17)
Consent to care and treatment - Outcome 2 (Regulation 18)
Care and welfare of people who use services - Outcome 4 (Regulation 9)
Meeting Nutritional Needs - Outcome 5 (Regulation 14)
Cooperating with other providers - Outcome 6 (Regulation 24)
Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
Cleanliness and infection control - Outcome 8 (Regulation 12)
Management of medicines - Outcome 9 (Regulation 13)
Safety and suitability of premises - Outcome 10 (Regulation 15)
Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
Requirements relating to workers - Outcome 12 (Regulation 21)
Staffing - Outcome 13 (Regulation 22)
Supporting Staff - Outcome 14 (Regulation 23)
Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
Complaints - Outcome 17 (Regulation 19)
Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.

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